USAble Life

Attention: Legal & Regulatory Department
P.O. Box 1650
Little Rock, Arkansas 72203-1650
Telephone (501) 375-7200 or
(800) 648-0271

Application for Extended Insurance Benefits
(Waiver of Premium)

For H.O. Use Only
Eff _____
PTD _____
Benefits _____

(To Avoid Delay Please Answer All Questions)

CLAIMANT'S/EMPLOYEE'S STATEMENT

1. Full Name (Last, First)				Social Security Number
2. Address	City	State	Zip	Phone Number

3. Date of Birth	Sex ☐ Male ☐ Female	4. Occupation (List the duties of your occupation at the time of disability.)
Height	Weight	

5. I have been unable to work because of this disability since Month_____ Day_____ Year_____	I returned to work on part-time basis on Month_____ Day_____ Year_____	I returned to work on a full-time basis on Month_____ Day_____ Year_____
6. Date of your accident o the date you first noticed the symptoms of your illness	Is your accident or illness related to your occupation	If yes, explain

7. Describe how and where accident occurred or describe the first symptoms of your illness

8. Date you were first treated for your illness or injury Month_____ Day_____ Year_____	Treated by Hospital _____ Name Address Doctor _____ Name Address
9. Have you ever had the same or similar condition in the past? Month_____ Day_____ Year_____	Treated by Hospital _____ Name Address Doctor _____ Name Address

The above statements are true and complete to the best of my knowledge and belief and I hereby authorize any hospital or physician who has treated me or other person who has attended me or examined me or any company or government agency to furnish to USAble Life or their representative, any and all information with respect to any illness, injury, medical history, consultations, prescriptions, treatments or benefits, and copies of all applicable records. A photostatic copy of this form will be as valid as the original.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in a claim for insurance may be guilty of a crime and subject to fines and confinement in prison.

Date: _____ Signature of Claimant/Employee: _____

EMPLOYER'S STATEMENT

1. Employee's Name	Policy/Certificate Number	Group Policy Number

2. Employee's Date of Hire	Employee's Effective Date of Ins.	Last Day Worked	Reason for Stopping Work	Returned to Work On

3. Occupation at Time of Disability

Employer	Date
Signature	Title
Name (Please Pint or Type)	Telephone ( )
Address	City State Zip

Please have your attending physician complete Page 2

ATTENDING PHYSICIAN'S STATEMENT

Name of patient _____ Date of Birth ____/____/____ (Mo / Day / Year)

Employer name _____ Group Policy No. _____

1. HISTORY
   (a) When did symptoms first appear or accident happen? ..... Mo. _____ Day _____ Year _____
   (b) Date patient ceased wok because of disability ..... Mo. _____ Day _____ Year _____
   (c) Has patient ever had same or similar condition? ..... ☐ Yes ☐ No If "Yes" state when and describe .....
   (d) Is condition due to injury or sickness arising out of patient's employment? ..... ☐ Yes ☐ No ☐ Unknown
   (e) Names and addresses of other treating physicians .....

2. DIAGNOSIS (including any complications)
   (a) Date of last examination ..... Mo. _____ Day _____ Year _____
   (b) Diagnosis (including any complications) .....
   (c) Subjective symptoms
   (d) Objective findings (Including current X-rays, EKG's Laboratory Data and any clinical findings)

3. DATES OF TREATMENT
   (a) Date of first visit ..... Mo. _____ Day _____ Year _____
   (b) Date of last visit ..... Mo. _____ Day _____ Year _____
   (c) Frequency ..... ☐ Weekly ☐ Monthly ☐ Other (Specifiy)

4. NATURE OF TREATMENT (Including surgery and medications prescribed, if any)

5. PROGRESS
   (a) Has patient ..... ☐ Recovered? ☐ Improved? ☐ Unchanged? ☐ Retrogressed?
   (b) Is Patient ..... ☐ Ambulatory? ☐ House confined? ☐ Bed confined? ☐ Hospital confined?
   (c) Has patient been hospital confined? ☐ Yes ..... ☐ No If yes, give name and Address of Hospital
   Confined from through

6. CADIAC (If Applicable)
   (a) Functional capacity (American Heart Ass'n) ..... ☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation) ☐ Class 3 (Marked limitation ☐ Class 4 (Complete limitation)
   (b) Blood Pressure (last visit) ..... _____ (Systolic/Diastolic)

7. PHYSICAL IMPAIRMENT (*as defined in Federal Dictionary of Occupational Titles)
   ☐ Class 1 – No limitation of functional capacity; capable of heavy work. No restrictions. (0-10%)
   ☐ Class 2 – Medium manual activity* (15-30%)
   ☐ Class 3 – Slight limitation of functional capacity; capable of light work* (35-55%)
   ☐ Class 4 – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity (60-70%)
   ☐ Class 5 – Severe limitation of functional capacity; incapable of minimum (sedentary*) activity (75-100%)
   Remarks:

8. MENTAL/NERVOUS IMPAIRMENT (If applicable)
   (a) Please define "stress as it applies to this claimant.
   (b) What stress and problems in interpersonal relations has claimant had on job?
   ☐ Class 1 – patient is able to function under stress and engage in interpersonal relations (no limitations)
   ☐ Class 2 – Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
   ☐ Class 3 – Patient is able to engage in only llimited stress situations and engage in only limited interpersonal relations (moderate limitations)
   ☐ Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
   ☐ Class 5 – Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)
   Remarks:

9. PROGNOSIS

	PATIENTS JOB	ANY OTHER WORK
(a) Is patient now totally disabled?	☐ Yes ☐ No	☐ Yes ☐ No
(b) What duties of patient's job is he/she incapable of performing?		
Do you expect a fundamental or marked change in the future?	☐ Yes ☐ No	☐ Yes ☐ No
(1) If yes, when will patient recover sufficiently to perform duties	Date ____/____/____ ☐ 1 Mo. ☐ 3-6 Mo ☐ 1 –3 Mos. ☐ Never	Date ____/____/____ ☐ 1 Mo. ☐ 3-6 Mo ☐ 1 –3 Mos. ☐ Never
(2) If no, please explain		

10. REMARKS

_____

_____

Physician's Signature	Provider ID #	Date
Physician's Name		Degree
Physician's Signature		Date
Address		Telephone ( )
City	State	Zip